U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

RECENT TRENDS IN THE NURSING HOME LIABILITY INSURANCE MARKET

June 2006

Office of the Assistant Secretary for Planning and Evaluation

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This report was prepared under contract #HHS-100-97-0019 between HHS's ASPE/DALTCP and Medstat. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Susan Polniaszek, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Susan.Polniaszek@hhs.gov.

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June 1, 2006

Prepared for
Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHS-100-97-0019

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BACKGROUND

In the mid 1990s, both insurers and nursing home providers enjoyed a relatively stable market for professional liability insurance.[1] Liability claims against nursing home were few, the cost of insurance was stable and affordable, and underwriting practices among insurers were relatively lax. Insurers did little to differentiate liability risks within the nursing home industry.

Today, it is a different story.[2,3] Litigation activity against nursing home providers for negligent care and abuse increased dramatically in the late 1990s, particularly in certain states. Many of the insurance carriers participating in the nursing home market incurred huge financial losses, and decided to leave the market altogether.[4,5] Correspondingly, many of the national nursing home chains, which are largely self-insured, incurred significant operating losses related to liability claims, putting additional financial pressures on an industry that was already in severe financial difficulty. As regulated insurance carriers left the market, the void was filled by "surplus line" carriers which are subject to less regulation by state insurance departments. The price of liability insurance for providers increased dramatically, while the terms and conditions of coverage became more constricted. Insurers took on less risk at higher prices. Moreover, those insurers that remained in the market tightened their underwriting practices to differentiate "high risk" and "low risk" providers. Providers with a history of liability claims or quality of care citations found themselves unable to purchase liability coverage at any price. In addition, new forms of risk pooling for liability exposure, such as captives, also emerged as alternatives to traditional insurance coverage.

This period of volatility in the nursing home liability insurance market also put increased focus on potential public policy responses in the form of tort reform. The nursing home industry contended that much of the increase in litigation activity was due to "frivolous" claims not related to negligent care or patient abuse. Consequently, a number of states enacted tort reforms that changed the legal framework under which residents and/or family members could seek damages for negligent or abusive care practices. States also placed limits on the amount of damages that could be awarded to plaintiffs and/or their family members, particularly non-economic damages for pain and suffering. The issue of whether tort reform is the appropriate policy response to the recent trends in the nursing home liability market is a matter of considerable policy debate among stakeholders, who hold widely divergent views on both the underlying causes of the insurance crisis, and its solution.[6,7]

STUDY DESCRIPTION

To help inform the public policy debate, the Department of Health and Human Services (HHS), Assistant Secretary for Planning and Evaluation contracted with Thomson Medstat to conduct a study on recent trends in the nursing home liability insurance market and their effect on the costs and availability of nursing home liability insurance. Medstat was directed to conduct this analysis through both qualitative and quantitative methods. Trends and issues related to nursing home liability insurance were examined through a review and synthesis of the available literature, and through discussions with key stakeholders. More detailed analysis of current trends in the nursing home liability insurance market was conducted through case studies of selected states. In addition, Medstat was directed to conduct a feasibility analysis of collecting detailed information on liability claims filed against nursing home providers, as well as to assess the feasibility of linking liability claims data with nursing home quality measures.

Medstat conducted interviews with key stakeholders with differing perspectives on the nursing home liability insurance market. Stakeholders included both for-profit and not-for-profit nursing home providers and assisted living providers, insurance industry representatives, insurance brokers, state insurance regulators, representatives from provider trade associations at the state and federal levels, plaintiff attorneys, defense attorneys, consumer advocates, state licensing and certification agency personnel, state Medicaid agency personnel, medical directors of nursing homes, geriatricians with large nursing home practices, and long-term care policy researchers. In addition, Medstat conducted case studies of five states: California, Florida, Georgia, Ohio and Texas. These states were selected because they were known to represent a range of trends in the liability insurance market: Texas and Florida were identified as states where there was particular uncertainty in the nursing home liability insurance market ; California was selected as a state with a fairly unique tort environment; Ohio was selected as a relatively stable market in comparison to most states; and Georgia was selected as a state that had not yet experienced the severe volatility of other states, but was considered to be potentially on the verge of a significant crisis, given its geographic proximity to Florida.

A concerted effort was made to collect facility-level information on liability claims from the nursing home industry. Provider-level data on liability claims are considered highly sensitive information by the industry, since the vast majority of claims are settled out of court and considered confidential. Understandably, providers do not want information about their liability claims history made available to the plaintiff's bar or to the general public. Consequently, in soliciting the nursing home industry to submit liability claims data for this study, the HHS established special precautions to protect the confidentiality of data submissions. Through an inter-agency agreement, the Agency for Health Care Research and Quality (AHRQ) was designated as the recipient and holder of liability claims information submitted by nursing home providers. The data were maintained in a secure environment within AHRQ, and access to the data was limited exclusively to staff authorized to work on the project. No provider-level data was released from the AHRQ secured environment.

Although the nursing home industry cooperated with the HHS in providing liability claims data for the study, the quantitative analysis had multiple limitations. First, although attempts were made to elicit data from a broad representation of providers, virtually all data submissions came from large national for-profit chains. Second, although providers were asked to submit a specific and common set of data items, providers generally submitted whatever data they maintained internally to manage their liability claims and operate internal risk management programs. Further, the data submitted usually included all *general* and professional liability claims, which are usually covered under the same insurance policy. For example, if a visitor to a nursing home slipped and fell on ice in the parking lot, this event (and any associated claim) was usually included in the data submission. Employee-related incidents (e.g. traffic accidents) and reported thefts in the facility were also generally included. Third, data submissions by providers generally included all internally-reported incidents and events that occurred in the facility, regardless of whether the incident or event in question eventually led to a professional liability claim. Providers generally collect information on all incidents and events as part of their overall risk management programs and then investigate all reported incidents and events quickly and thoroughly in order to ensure that adequate documentation of the event is available should a liability claim eventually be filed. Fourth, while the data submissions generally included information on *estimated* liability costs associated with the incident or event, the actual settlement cost, if there was one, was often not available in the database. Medstat was informed that providers are often themselves unaware of the eventual settlement cost of a professional liability claim, which is held confidential between the insurance carrier, the defense attorney and the plaintiff attorney. Due to these limitations, the conclusions that could be drawn from the quantitative component of the study were extremely limited. This report is based primarily on the qualitative components of the study.

This report first presents a summary of the liability insurance and tort reform environment in each of the five states that were selected for case study analysis. Next, the report describes national trends in litigation and claims against the nursing home industry. The report then presents trends in the nursing home liability insurance market across the country, in response to the rise in liability claims and costs. Last, the report discusses how various states have responded to the nursing home liability insurance crisis through the enactment of tort reform legislation.

CASE STUDY FINDINGS

The five case studies confirmed that changes in the nursing home liability insurance market have played out quite differently across state markets. Moreover, the public policy response was also highly diverse, depending upon the severity of the situation. Texas and Florida experienced more severe situations. The Medstat study began in the fall of 2002, approximately one year after the enactment of Senate Bill 1202 (S.B. 1202) in Florida, a major tort reform initiative intended to bring stability back to the liability insurance market in that state. Thus, our case study focused on the impact of S.B. 1202 several years after its enactment. Although there was some evidence of a decline in litigation activity in Florida since the enactment of the legislation, regulated insurance carriers had still not re-entered the market there, and many nursing home providers were still operating without any liability insurance coverage at all.[8] Another trend was that many of the national nursing home chains which had operations in Florida had completely divested themselves of all their facilities in that state, in order to minimize their liability exposure.

The Texas case study was conducted coincidentally with the legislative debate in that state regarding the enactment of House Bill 4 (H.B. 4), a major liability reform initiative that was not limited to the nursing home market, or even the health care market.[9] The State of Texas had been experiencing a liability insurance crisis across a broad swath of industries, including health care, long-term care, trucking, housing, and manufacturing. H.B. 4, which was debated fiercely in the state legislature in 2003, placed "hard caps" on economic and non-economic damages awarded in tort cases. The major lesson from the Texas case study was that the impact of tort reform depends on the detailed provisions of the legislation. As in Florida, the impacts of tort reform in Texas were not immediate. Nursing home insurers were cautious about re-entering the market until they saw solid evidence of reduced liability exposure.

The legal environment in California was unique. Nursing home cases were litigated under two related statutes that were enacted with somewhat contradictory policy intentions. First, the Medical Injury Compensation Reform Act, enacted in 1975, was intended to specifically limit legal actions against medical care providers, and is considered model legislation for medical malpractice reform initiatives across the country.[10] The second statute, the Elderly Abuse and Dependent Adult Civil Protection Act (EADACPA) was, on the other hand, enacted specifically to increase financial incentives to plaintiffs and plaintiff attorneys to bring civil actions against providers who abuse or are otherwise negligent to nursing home residents or other elders. Consequently, litigation against nursing home providers plays out in the intersection of these two statutes in a manner that adds considerable complexity to individual cases. The amount of legal resources invested in litigating individual cases in California, as reported by both plaintiffs and defendants, was considerable. Further, legal ambiguities created by the intersection of these statutes in California were still seeking clarification in various appellate courts around the state.

Georgia did indeed appear to be on the verge of a major increase in litigation activity. The concern of nursing home providers in Georgia was that plaintiff attorneys who had developed specialized expertise in nursing home litigation in Florida had

saturated that market and were looking northward to Georgia to expand their practices.[11] Although the frequency of litigation in Georgia was clearly not on the scale of Florida or Texas, insurance carriers indicated anticipation of a significant growth in litigation activity, and had raised prices on their insurance products accordingly. Georgia has also seen significant growth in the use of captives as an alternative insurance arrangement.

Another key issue that was most evident in Georgia was the importance of venue. Juries in urban counties were perceived as considerably more sympathetic to plaintiffs, and more likely to award significantly higher damages, than juries in rural counties. This perception had in fact borne out in the few nursing home cases that had gone to jury trial in Georgia. Thus, there was reportedly considerable maneuvering by plaintiff attorneys to have cases litigated in venues considered to be more favorable to the plaintiff side. Indeed, when the Georgia state legislature eventually enacted tort reform legislation in February 2005, the establishment of venue was a central provision of the legislation.

In comparison to the other case study states, the nursing home liability insurance market in Ohio was far less volatile.[12] Although regulated carriers had left Ohio as they had in other states, leaving only surplus line carriers to serve the industry, litigation activity in Ohio, according to stakeholders, was less than observed in other states. A unique characteristic of Ohio was the higher regard with which the public viewed the nursing home industry. The higher public persona of the nursing home industry in Ohio may be related to the fact that the industry in Ohio is dominated by small privately-owned companies, many of which are family owned and operated. The owners of these facilities are generally viewed as an integral part of their local communities, and in rural areas, often one of the larger and more stable employers. Stakeholders repeatedly mentioned that it was difficult to bring lawsuits against nursing home owners who were regarded so highly by the communities in which they resided. As one Ohio defense attorney succinctly put it: “it’s all about the audience.”

NURSING HOME LITIGATION TRENDS

A major factor contributing to the recent volatility in the nursing home liability insurance market has been increased litigation.[13] Losses in the nursing home market rose dramatically in the late 1990s. There were significant increases in both the frequency of liability claims and in the size of damages awarded, primarily through negotiated settlements. However, reliable empirical data on the increase in frequency and size of liability claims are lacking, and the five case studies made it clear that litigation activity varied dramatically across states. Consequently, considerable disagreement remains among stakeholders regarding both the magnitude of litigation activity, as well as the relationship between increases in liability claims and the cost and availability of liability insurance.

A primary source of information about litigation trends is a series of studies conducted by Aon Risk Consultants for the American Health Care Association (AHCA), a nursing home trade association representing primarily for-profit nursing homes, including the large national chains.[14,15,16,17,18] Sponsored by AHCA, Aon conducted five annual studies from 2001 through 2005 on general and professional liability losses incurred by nursing home operators. The data for the Aon studies came from nursing home providers that voluntarily responded to a data call from AHCA to participate in the study resulting in a limited convenience sampling of providers. Over the five years that the studies were conducted, between 60 and 108 separate nursing home operators, provided claims data. While this represents only a small percentage of all nursing home operators, the operators that participated in the study included many of the large for-profit nursing home chains. For example, in the 2004 study, just eight operators accounted for 77% of the total liability losses reported. The nursing homes participating in the Aon studies represented about 23-25% of all nursing home beds in the country.

Although the Aon studies have served as a primary data source on nursing home liability trends in recent years, they have also been criticized for having a number of limitations that compromise the generalizability of the study findings to the entire nursing home industry. These limitations include:

- The providers which contributed data to the Aon studies were dominated by large for-profit, self-insured chains that were known to have incurred the highest rate of liability claims, and thus did not represent the liability experience of the nursing home industry as a whole.

- The providers in the Aon studies operated facilities that were disproportionately located in states with the highest rate of liability claims. For example, while the data contributors represented about 25% of all nursing home beds nationwide, they represented 54% of all beds in the state of Florida, 38% of all beds in Mississippi, and 75% of all beds in Alabama. The national average liability loss data reported by Aon did not adjust for these geographic imbalances.

- Since it generally takes an average of three to four years for a liability claim to be resolved, estimated loss costs for the more recent years were highly dependent upon actuarial assumptions made by Aon about the ultimate resolution of

outstanding claims. These assumptions were generally based upon historical trends, which may or may not continue in the same direction.

- Loss costs reported by providers participating in the Aon studies included *general* liability losses as well as professional liability losses. Thus, liability claims unrelated to the direct care of nursing home patients (e.g., lawsuits brought by employees) were included in Aon's estimates. Aon did not disaggregate what proportion of total loss costs was related to general liability claims and what proportion was attributable to professional liability claims.

- Given sponsorship of the Aon studies by AHCA, the studies have been criticized as having a political agenda behind them (i.e., that AHCA wished to demonstrate a need for state tort reform to address the problem of "runaway" lawsuits against nursing home providers).

Despite these limitations, the Aon studies are the most cited reference on nursing home liability trends in recent years. However, any conclusions from these data should be interpreted with appropriate caution. Table 1 presents average national loss costs estimated by Aon in the four studies conducted from 2002 through 2005. The studies showed a very rapid increase in loss costs in the four-year interval from 1996 through 2000, averaging about 26% annually over this period. Over the following four years, loss costs continued to increase, although at a far reduced rate. In its most recent study, released in March 2005, Aon estimated that annual loss costs increased on average by about 3% annually between 2000 and 2004 for the providers represented in the study. However, over the eight-year period from 1996 to 2004, according to the Aon study, liability losses still increased by over 180% for these providers.

A second study on this topic was conducted by the Insurance Services Office (ISO) in 2002.[19] The ISO is a research organization that provides statistical and research support to state Departments of Insurance. To conduct these studies, states mandate regulated insurance carriers to provide various data to the ISO for analysis. In 2002, the ISO of New Jersey conducted a study of liability claim costs in the nursing home industry for those nursing home providers covered by commercial insurers.

The ISO study differs from the Aon studies in a number of important respects:

- Nursing home providers represented in the ISO study were providers that purchased liability insurance from commercial insurance companies regulated by state Departments of Insurance. Thus, it excludes providers who are either: (a) self-insured, or (b) covered by non-regulated insurers. As previously discussed, these excluded providers are more likely to have incurred higher liability losses than the providers included in the ISO study.

- The ISO database was predominantly comprised of policies with limits of $1 million on coverage. Thus, in its analysis, ISO assumed no settlements or awards in excess of $1 million, since, in theory, those excess payments were the responsibility of the provider, not the insurer.

- The geographic distribution of providers represented in the ISO study differed markedly from the geographic distribution represented in the Aon studies. While the total number of beds in the ISO study represented about 26% of all beds in the United States--similar to the Aon studies--the ISO sample was more highly skewed to states with lower litigation activity. For example, only 15% of all nursing home beds in Florida were represented (compared to 55% in the Aon study) and only about 5% of all beds in Texas (compared to 19% in the Aon study).

Despite marked differences in the samples of nursing home providers represented in the Aon and ISO studies, it is interesting to compare their results, as shown in Table 2. Estimated loss costs per occupied bed, claim frequency, and claim severity were all significantly lower in the ISO study than in the Aon studies. For example, during 1998-2000, as shown in Table 2, ISO estimated average loss costs of $209 per occupied bed. During the same time period, Aon estimated average loss costs of approximately $1,800 per occupied bed, almost nine times higher.

Whether the differing results in the Aon and ISO studies primarily reflect differences in the underlying liability experience of the nursing home providers represented in the respective studies, or whether there are additional reasons for the differing study results, such as actuarial assumptions used in estimating loss costs, is hard to tell. Given the marked differences in the composition of providers included in the two respective studies, it is reasonable to conclude that a large amount of the difference in study results reflects the underlying litigation experience of the provider samples represented in each study.

A third study on nursing home litigation conducted by researchers at the Harvard School of Public Health used a survey approach to measure litigation activity. Using a publicly-available legal directory, the researchers identified 464 plaintiff and defense attorneys nationwide who listed their practices as including “nursing home” or “long-term care” law. The researchers surveyed these 464 attorneys in the year 2001 using a web-based survey instrument, achieving a response rate of 60%.

The results of the study showed a relatively high rate of nursing home litigation. Based upon the survey results, the researchers estimated a total of 8,253 claims and total compensation payments (excluding defense costs) of $2.3 billion in the 12 months prior to the survey, as well as an average payment amount of $406,000 per compensated claim. The latter estimate of claim severity is significantly higher than reported in either the Aon study or the ISO study, and may be attributable to the fact that attorneys tend to recall only those cases with higher settlement amounts. If the total number of estimated claims is divided by the number of total occupied nursing home beds in the United States (about 1,620,000) then claim frequency nationwide would equal about 5.1 per 1,000 beds, which is higher than the ISO estimates but considerably lower than the Aon estimates.[a] If the same assumptions are applied to total compensation payments, then the average loss cost per bed (again excluding defense costs) would be in the range of $1,419 per bed, considerably closer to the Aon

[a] Note that the Harvard study only includes estimates of professional liability claims, and does not include general liability claims.

estimates than the ISO estimates. The Harvard study is the only study that attempted to measure the full scope of litigation activity across the nursing home industry. As in the Aon studies, a very high percentage of litigation activity, as well as total loss costs incurred by the entire industry, were attributable to litigation activity in just two states: Florida and Texas.

A fourth study attempting to measure the magnitude of nursing home litigation activity was conducted by the California Advocates for Nursing Home Reform (CANHR) in 2003.[20] The study methodology employed by CANHR was a comprehensive review of California Supreme Court civil indexes in counties that represented approximately half of all nursing home beds in the state. The review identified all general jurisdiction lawsuits that included a claim for elder abuse. This is because liability claims against nursing homes in California are almost always brought under the EADACPA elder abuse statute discussed earlier in this report.

The CANHR study found a much lower level of litigation activity in California than reported in the Aon studies. Over the three-year period from 2000 to 2002, CANHR identified an average of 166 lawsuits per year in the sample counties, equal to a claim frequency rate of 2.8 claims per 1,000 beds. For the same time period, Aon estimated a claim frequency rate of about 11.5 claims per 1,000 beds in California. Furthermore, CANHR found no evidence of increasing frequency--the number of lawsuits filed in 2002 was less than the number filed in 2001. CANHR also found a strong correlation between the probability of a nursing home being sued with public records of poorer quality care. The facilities with the highest number of lawsuits filed against them had been more frequently cited for deficiencies, and received more consumer complaints, than facilities that were not sued. Based upon its findings, CANHR titled its study *Much Ado About Nothing: Debunking the Myth of Frequent and Frivolous Elder Abuse Lawsuits Against California's Nursing Homes.*

One potential criticism of the methodology employed by CANHR is that it only identified liability claims that had progressed to the point of the plaintiff filing a lawsuit in the county courts. Industry representatives stated that many liability claims are settled before ever progressing to the stage of the actual filing of a lawsuit. Expressing a contrary view, one plaintiff attorney interviewed during the California site visit argued emphatically that defendants *never* settled an EADACPA claim unless an actual lawsuit had been filed.

What conclusions can be drawn from these highly disparate studies, and their highly disparate results? We believe that based on these study results, the findings of the case study site visits, interviews with key stakeholders, and a review of the literature on nursing home liability, that the following general observations are reasonable:

- There has been a significant increase in litigation activity against nursing homes over the last decade. This increase in litigation was particularly pronounced during the period from 1995 to 2000, but since the year 2000, has leveled off considerably.

- There is significant geographic variation in the rate of litigation activity against nursing home across the country. Florida had (and probably still has) the highest

rate of litigation, followed by Texas. For whatever reason, the level of litigation activity against nursing homes has been higher in southern states than in northern states.

- Large, for-profit, multi-regional nursing home chains have been sued at a higher rate than smaller independent operators, either for-profit or not-for-profit. However, all types of nursing home operators have seen increases in their liability exposure.

- Lawsuits against nursing homes are rarely defended in a jury trial. Most liability claims are settled out of court, with the vast majority settled with some compensatory payments to the plaintiff. Defendants believe that juries in nursing home litigation cases are extremely unpredictable, and generally prefer to settle the case than risk the chance of a large damage award in a jury trial.

- With the enactment of nursing home residents' rights statutes as well as elder abuse statutes in many states, the statutory basis for bringing lawsuits against nursing homes has broadened in recent years.[21]

NURSING HOME LIABILITY INSURANCE MARKET TRENDS

Concurrent with the increase in litigation activity, the market for nursing home liability insurance has undergone major changes over the last decade. In 2005, the market bears little resemblance to 1995, even in states where there has been little litigation activity. The market is still changing rapidly, and it is difficult to predict what it will look like in another five or ten years. Looking retrospectively, the market has undergone the following changes over the last decade:

Most carriers that were in the nursing home liability insurance product-line in the mid 1990s have left the market.

Insurers, most of which were commercial admitted carriers that had large market shares in the nursing home liability insurance market, incurred large financial losses in the late 1990s.[22,23] Both providers and insurers reported that liability insurance premiums were generally priced at about $50/bed for a $1 million "occurrence-based" policy in the mid 1990s, with insurers doing very little underwriting or risk management. These insurers, particularly those with a large market presence in Florida and Texas, were hit hard by the rise in liability costs in these states, and elsewhere. St. Paul Insurance Company, one of the largest national carriers in the market, decided to get out of the market altogether in 1999. Other major carriers exiting the market included Guaranty Insurance Company, Employers Reinsurance Corporation, Reliance National Insurance Company, the Doctors Company, USF Insurance Company, Agricultural Excess and Surplus Insurance Company, Admiral Insurance Company, and the Hartford Life Insurance Company, which for many years had an association with the American Association of Homes and Services for the Aged. Most of these companies left the market, or stopped issuing new policies, in the late 1990s and early 2000s.

In most cases, these companies' decision to leave the market was an easy one. The nursing home liability insurance market is not a large one, and for the larger liability insurers, nursing home insurance was usually a side product-line, for which the insurers had built little if any infrastructure. When liability losses began to exceed premium revenue, many companies simply decided to leave the market altogether rather than risk additional financial losses.

Limited access to the reinsurance market was another factor in the exit of commercial carriers from the market.

Most commercial insurers retain only limited risk for their product-lines, and sell off the remaining risk to the reinsurance market. Rather than assessing the risk of individual policyholders, reinsurers tend to assess risk on a product-line and/or geographical basis. When the nursing home liability insurance market began to incur losses in the late 1990s, most reinsurers decided to stop assuming any risk in the nursing home product-line. In turn, the lack of access to the reinsurance market influenced the decisions of commercial carriers to get out of the market.

As admitted carriers left the market, surplus line carriers entered.

Policyholders may purchase insurance in either the "admitted" or "non-admitted" insurance markets. Insurance companies that operate in the non-admitted market are also called "surplus line" carriers.[24,25] Admitted carriers are commercial insurers that must comply with state Departments of Insurance review and regulation of policies, forms, and rates. One advantage of admitted coverage is that admitted carriers can participate in the protection of the state's guarantee fund in the event of a financial insolvency. There is also some marketing advantage for an insurer to write on an admitted basis, because some brokers, facility providers and lenders perceive value in state oversight and participation in the guarantee fund.

In the surplus market, because rates and forms are not subject to state regulation, the insurer has greater flexibility in how coverage is designed and priced. Surplus carriers are also able to respond more rapidly to changes in the marketplace. Changes in coverage forms and application protocols, when needed, can be put into place more quickly when coverage is not subject to a lengthy compliance review by the state. However, surplus line carriers have no protection from the state's guarantee fund (which actually benefits providers insured by an insolvent insurer more than it benefits the insurer itself). In addition, surplus carriers must pay an "excess and surplus lines" tax that is not levied on admitted carriers.

Virtually every nursing home provider we interviewed during the study, in both the case study states and elsewhere, indicated that they had been forced to switch insurance carriers within the last few years. Most were forced to switch because their former carrier had stopped renewing policies. These providers (generally through their insurance brokers) were then forced to shop for new carriers in the surplus market. It was at this time that many providers experienced the shock of a major increase in premium costs for liability insurance, along with significant reductions in coverage. During the course of our study, stakeholders identified only two companies (AIG and CNA) that were still writing policies on an admitted basis. These two companies had stayed in the business by drastically changing their underwriting practices in order to differentiate liability risk among applicant policyholders.[26] Thus, in some cases, current policyholders of AIG and CNA were not allowed to renew their policies due to the fact that they did not meet the new underwriting criteria.

Terms and conditions of liability insurance coverage changed dramatically.

In addition to charging higher prices, most surplus line carriers shifted a greater percentage of the risk back onto providers. Deductibles, which could be anywhere from $10,000 to $1,000,000, were imposed before insurance coverage began. Deductibles were sometimes imposed on a *per claim* basis, rather than a total policy basis. Policies often had new limits on the amount of coverage provided, so that insurers only provided risk protection within narrowly defined risk corridors.

Another important change in coverage was a switch from policies written on a "claims occurrence" basis to policies written on a "claims made" basis. "Claims

occurrence" policies provide coverage for all incidents and events that occur during the term of the policy, regardless of when a liability claim is made, or when a lawsuit is settled. Policies written on a "claims made" basis only provide coverage for insured events that both occur and *for which a claim is made* during the term of the policy. Thus, if an incident occurs, but the policy is terminated before a claim is made, liability for the incident is not insured. This switch in coverage from an "occurrence" basis to a "claims made" basis allows insurers to limit their risk if a specific policyholder demonstrates increased liability risk--for example, an increase in deficiency citations.

Coverage has also changed in terms of exclusions for specific types of losses. Some of the newer policies impose specific and additional coverage limits for losses based on sexual or physical abuse, and thus might exclude paying a claim if "abuse" was found to be an underlying cause for the claim. Insurers also can rely on "fraudulent statements" on the application as the basis for denying a claim in certain instances. For example, insurers may offer policy provisions that would limit their obligation to cover a loss if the provider did not adequately represent its risk (e.g., provided false or misleading information on the application, such as misrepresenting the acuity of residents typically cared for or qualifications of staff) or if the provider failed to carry out a "risk management" protocol that it indicated on the application was a routine element (e.g., a fall prevention protocol). An insurer might deny a claim for a loss based on actions of a specific employee with a criminal background if it was revealed that the provider failed to do a background check before hiring the employee. Many policies also exclude or limit claims related to punitive damages.

Data on the current costs of liability insurance are sporadic.

While the costs of liability insurance coverage have increased for all providers, reliable data on current prices in the marketplace are not available. The switch from admitted to surplus line carriers has made the collection of data more problematic, because surplus line carriers are not required to report their rates to state Departments of Insurance.[27,28] Further, whereas in the past, rates were fairly comparable within the same geographical area, rates can now vary significantly from provider to provider based upon the carrier's assessment of each provider's individual liability exposure. Changes in the terms and conditions of coverage also make it difficult to fairly compare rates across policies.

In its latest study, Aon provided limited data on the insurance experience of the subset of providers in its study sample that had commercially-provided insurance. This included 53 of the 76 participants in the study that represented about 45% of the nursing home beds in the study. These providers reported some attenuation in premium increases over the 2002-2004 time period, in comparison to the previous two years. However, providers reported continued reductions in liability limits, as well as increased deductibles. Smaller providers reported the greatest increases in premium prices.

Without reliable data on the actual costs of liability insurance for nursing home providers, it is difficult for policymakers to assess the magnitude of the "crisis" in the liability insurance market, and whether the market is returning to a more stable environment.

Improved underwriting has become increasingly important to profitability.

For those insurers that remain in the nursing home liability insurance market, improved underwriting practices have become increasingly critical to financial performance. Insurers have invested significant resources in improving their ability to assess liability risk for both individual providers and for groups of providers.[29] The market has become increasingly competitive in this regard, meaning that the expertise that an insurer is able to bring to the market in terms of its underwriting capacity has increasingly become a competitive factor in the marketplace. Those insurers that demonstrate superior performance in both evaluating risk and pricing risk appropriately are those that are able to achieve higher profitability. This was generally not the case ten years ago.

Applications for insurance coverage now request an extensive amount of information from providers. Insurers are also more prone to purchase additional information from third-party vendors such as CareScout and HealthGrade, which grade facilities based upon their own research about quality performance and claims histories. Underwriting criteria have become increasingly proprietary to the point where many insurers prefer not to discuss their methodologies for rating insurance applicants.

One outcome of this increased emphasis on insurance underwriting is that providers with poor claims histories and/or a record of providing lower quality care find it increasingly difficult to purchase insurance coverage.[30,31] These providers can be denied coverage altogether, or the price and terms of purchase can be financially prohibitive. Other providers complained that with the new underwriting criteria, even one liability claim, regardless of its merits, could spell disaster in terms of that provider's ability to access or afford insurance in the future.[32]

Risk management programs are increasingly utilized as a management tool for reducing liability risk.

Risk management programs are structured approaches to purposefully limit liability risk. They include systematic efforts to improve and maintain high standards for care quality, but can also include additional management techniques to minimize liability exposure, such as improving written documentation. They are often formalized within the management structure of nursing home providers in the form of Risk Management Committees, and/or a designated Director of Risk Management, along with formal Risk Management plans that are implemented and monitored by senior management.[33,34]

Risk management programs were usually designed and implemented by providers, but there were also instances of liability insurers developing their own programs, which they then mandated on their policyholders as a condition of coverage. This latter practice was often controversial, since providers sometimes complained that insurers were not knowledgeable about sound care practices, and had designed risk management programs simply from reviewing the literature on the subject.

Risk management programs can have a variety of difference approaches and components. Examples include:

- Profiling prior cases that led to liability claims and limiting exposure to similar types of cases going forward, including changing admission practices to reduce admissions of cases that have a higher probability of leading to lawsuits.

- Intensified quality improvement programs specifically targeted to reduce incidents that most frequently lead to litigation (e.g., elopements).

- Structured initiatives to actively engage family members in the care management process in order to educate families about nursing home care management processes, and the realities of maintaining functionality among nursing home residents, as well as to develop informal relationships with family members that may lessen the likelihood that the family will pursue a legal claim should an adverse event occur.

- Improved documentation initiatives to ensure that the care and interventions provided to residents are always adequately documented in the patient record, and to ensure that physician orders are followed effectively. Lack of adequate documentation was frequently cited as a contributing factor to the settlement of liability claims.

A key issue for providers was finding financial resources to support risk management programs over and above their usual quality assurance and regulatory compliance activities. Risk management programs were more frequent among large companies with the resources to design and implement programs at the corporate level. Small independent providers were more limited in their ability to undertake risk management programs that added costs to daily operations.

Volatility in the nursing home liability insurance market has led to the creation of alternative markets for reducing liability risk.

Reduced accessibility and increased costs of commercial liability insurance for nursing home providers has opened the door for the alternative market. The alternative insurance market consists of various forms of self-insurance that retain risk instead of transferring it: self-insurance, risk retention and risk purchasing groups, captives, rent-a-captives, and sponsored captives (Joint Underwriting Associations).

Captives are essentially self-formed risk pools of providers that share risk among the members of the captive.[35] They can also be characterized as “new” insurance companies. Some captives are written on insurance paper to satisfy bond requirements to “have insurance” and while others are simply self-insured across the members of the captive. The traditional captive has joint liability as well as shared administrative costs among its members. One obvious advantage of this alternative insurance approach is that there is no insurance company profit or load on the premium costs.

In a traditional captive, the members are also responsible for conducting their own underwriting. That is, the members of a captive must decide among themselves with

whom they wish to share liability risk. There must be a sufficient number of members for the captive to be adequately capitalized, while at the same time limiting membership to facilities with low liability risk. Another variation on the risk retention captive is what's called a "cell captive" where the participants share administrative expenses but not risk.

The most common form of alternative nursing home insurance is a joint underwriting association (JUA), a state-sponsored organization that creates insurance pools and functions as an insurer in markets without a significant number of licensed insurers. A JUA has the power to sell insurance policies, collect premiums, and purchase reinsurance and it can usually guarantee a certain level of premium rates to its members. It also can levy surcharges on policyholders and, in some cases, on licensed insurers selling liability insurance, to create reserves to pay claims.

States that allow nursing facilities to buy-in to their JUA include Florida, Texas, Arkansas, California, Minnesota, Nebraska and Pennsylvania. Eligibility for a JUA may in some states come in tandem with a statute requiring nursing facilities to maintain liability insurance (e.g., Florida and Texas). Other state requirements can include requiring the state insurance commissioner to adopt best practices for risk management and loss control. Some states (e.g., Texas) fund their JUA reserves using a public bonding authority; others (e.g., Florida) have a Medicaid waiver to use a portion of the Medicaid nursing home payment as capital for the risk pool.

The Texas JUA was established as an "insurer of last resort" by legislation (S.B. 1839) in 2001. As mentioned previously, the Texas JUA uses facility characteristics and a risk assessment tool to adjust premiums for facilities participating in the JUA risk pool. Although there is a 30% discount for non-profit facilities, premiums through this alternative risk pool are reportedly "no better than what are available on the market." According to the Texas Health Care Association and Texas Association for Homes and Services for the Aging, only about 40 nursing homes had elected to participate in the JUA. The state was conducting a survey of nursing home providers to learn more about why more facilities had chosen not to participate in the JUA.

There are also other forms of alternative insurance; for example, Indiana has the Indiana Voluntary Market Assistance Plan, an attempt to retain writers and attract additional insurers for commercial liability insurance coverage. Participants agree to quote for at least one of five applications received in the program. The program is available to facilities that have experienced three declines of prior insurance including at least one from an excess and surplus line insurer.

Key factors for providers to consider in deciding whether to join a captive risk retention group include: (1) the size of the risk pool and the liability experience of the other members of the captive; (2) how risk is shared across members; (3) capitalization requirements needed to fund reserves; and (4) entry and exit requirements established for the captive.

In Ohio, a new insurance captive was formed under the sponsorship of an insurance broker with specialized expertise in nursing home liability.[36] The brokerage firm, and the members of the captive, believed that the commercial market for liability insurance had overreacted, and that the market was overpriced. The members of the

Ohio captive also believed that the prices charged by commercial carriers for Ohio providers reflected liability risk in other states with higher rates of litigation activity. In brief, the members of the Ohio captive believed they could reduce insurance costs by forming their own risk pool, rather than participating in the risk pools represented by the policyholders of the commercial carriers. By the end of 2004, about 25% of the providers in Ohio had become members of the captive.

Some observers of the marketplace (e.g., brokers) believed that many providers were naïve in thinking that they could do a better job than commercial carriers in providing insurance coverage through captives. There was considerable skepticism expressed about whether captives could exercise the political discipline needed to maintain strict underwriting standards (e.g., excluding fellow providers from participation in the captive). Another concern was whether captives could achieve adequate capitalization, particularly if they were not able to purchase reinsurance.

During the course of the study, a number of new captives were formed. However, captives in this market had not been in existence long enough to make any conclusions about their viability over the longer term.

STATE TORT REFORM INITIATIVES

Many state legislatures have responded to the rise in litigation against nursing homes and the resulting decrease in the availability of insurance by enacting tort reform laws that are intended to limit liability claims and/or losses to some degree.[37] These initiatives have been strongly supported by the nursing home industry, which has advocated that tort reforms are absolutely essential for constraining liability costs. While acknowledging the right of injured residents to seek fair compensation for damages through the courts, the industry has also contended that improvements in care quality are not sufficient to restrain the growth in litigation activity.

Tort reform efforts can be organized into three categories: measures that restrict access to the courts, reforms that regulate liability conditions and processes, and measures that limit compensation payments to plaintiffs and their attorneys. Table 3 summarizes recent tort reform efforts in a number of states that impact the nursing home industry.

Restricting Access to the Courts

In May of 2001, the Florida Legislature enacted S.B. 1202, repealing many of the more plaintiff-friendly measures that had been included in the Florida Patients' Bill of Rights law. Among other measures, the bill shortened the statute of limitations for initiating an action against a nursing facility to two years. In 2002, Ohio enacted H.B. 412, extending state tort liability reforms for hospitals and physicians to include licensed nursing homes. Among other measures, the Ohio law established a one-year statute of limitations for bringing suits against nursing facilities, their employees, and suits brought under Ohio's Residents' Rights Law. The States of Louisiana, Mississippi, Pennsylvania and Nevada each shortened their statutes of limitations for actions against nursing homes; Louisiana's S.B. 748 (2003) shortened their statute of limitations to three years, the enactment of Mississippi's H.B. 2 (2002) reduced their statute of limitations to two years, Pennsylvania's H.B. 1802 (2002) set a seven-year statute of limitations, and Nevada's A.B. 1 (2002) set their statue of limitations at three years.

Modifying Liability Rules

Florida's S.B. 1202 includes the establishment of a "reasonable care" negligence standard to replace the former strict liability standard applied to nursing facilities and their nursing staff. Ohio's H.B. 412 requires plaintiffs to prove that a facility demonstrated negligent or intentional misconduct in order to be awarded compensatory damages in suits with a patient bill of rights cause of action. Arkansas' H.B. 1038 (2003) modifies joint and several liability so that defendants who are found to be only partially at fault are responsible for a proportionate percentage of the damage they caused. In a 2004 special session, the State of Mississippi enacted H.B. 13, abolishing the rule of joint and several liability. In similar actions, Oklahoma enacted H.B. 2661 (2004), restricting joint liability to only defendants who are more than 50% at fault, and Nevada's A.B. 1 prohibited the application of the rule of joint and several liability in the

recovery of non-economic damages for medical liability claims. Pennsylvania's S.B. 1089 (2002) prohibits the application of the rule of joint and several liability in the recovery of all damages, except when a defendant has been found liable for intentional fraud or tort or been held more than 60% liable. Also in Pennsylvania, H.B. 1802 bars individuals from suing for damages that were paid by a health insurer.

Capping Damage Awards

The most common type of tort reform has been measures which limit or cap damages awarded to plaintiffs and their attorneys. In Florida, S.B. 1202 places caps on punitive damages at the greater of three times compensatory damages or $1 million, except in cases where it is determined that the defendant was motivated solely by financial gain and where the defendant was aware of the danger in which they were placing the resident, in which case punitive damages are limited to the greater of four times compensatory damages or $4 million. The Florida measure places no caps in cases where it is determined that the defendant intentionally harmed the claimant. Additionally, this Florida legislation eliminates of the recovery of attorney's fees for cases involving injury or death. Arkansas' H.B. 1038 and Idaho's H.B. 92 (2003), similar to the Florida measure, cap punitive damages at the greater of $250,000 or three times compensatory damages, with Arkansas setting a maximum at $1 million. In 2003, West Virginia's H.B. 2122 capped non-economic awards in medical professional liability actions at $250,000.

The State of Texas enacted H.B. 4 in 2003, limiting non-economic damages to $250,000 per facility and placing a $500,000 limit on claims involving multiple providers. In the same year, the Louisiana legislature limited non-economic damages at $500,000 (S.B. 748, 2003). Likewise, Ohio's S.B. 281 (2003) limits non-economic damages at $350,000, increasable up to $1 million, Mississippi's H.B. 13 caps non-economic damages at $500,000, and Nevada's A.B. 1 limits non-economic damages in medical liability cases to $350,000. In 2004, the Oklahoma Legislature enacted H.B. 2661, capping non-economic damages at $300,000 in medical liability cases, excepting wrongful death actions.

Of the various tort reform initiatives enacted by states in recent years, the Texas tort reform bill (H.B. 4) is generally viewed by both providers and insurers as the legislation that has the greatest chance of reducing liability costs. This is because the Texas bill includes "hard" caps on economic and non-economic damages, *as well as punitive damages*, with no exceptions for exceeding the caps. Nonetheless, it is also expected that the constitutionality of the Texas tort reform bill will be contested in the courts, which is the reason why insurers have still not returned to the Texas market to any great extent.

DISCUSSION

The future of the nursing home liability insurance market remains uncertain. While the Aon studies suggest that liability costs are leveling off from the dramatic increases of the late 1990s, the Aon data are not representative of the nursing home industry as a whole. Today's domination of the market by surplus line carriers that are excluded from state reporting requirements makes the collection of reliable data on current trends in the marketplace all the more difficult.

In 1995, the nursing home liability insurance market was small and not controversial. At an average premium of $50 per bed, the total size of the market was only about $85 million. If self-insured beds are excluded, the commercial market was actually less than $50 million. Today, if we conservatively assume an average premium cost per bed in the range of $800-$1,000, the total size of the market is in the range of $1.4-$1.7 billion annually. Thus, while there may be more risk in the market for commercial insurers, there is also considerably more financial opportunity as well. It is reasonable to conclude for insurers to be profitable in this market, they will have to be considerably more sophisticated about their liability exposure than those who were in the market ten years ago.

The future of the nursing home liability insurance market is obviously highly dependent upon the future of nursing home litigation. Although law firms that have developed specialized practices in nursing home litigation in Florida and Texas have made efforts to expand to other states, these expansions have, to date, not been remarkably successful. Whether their lack of success in expanding to other states is attributable to quality of care differences across states, different legal environments, or differences in jury behavior, is difficult to ascertain. Nonetheless, considerable anxiety remains in the provider and insurer communities that the highly successful methods and strategies developed by these firms will eventually spread nationwide. While legislatures in many states have enacted tort reform initiatives that have the intent of mitigating nursing home litigation, and liability costs, the effectiveness of these policy responses remains largely untested.

Consumer advocacy groups remain strongly opposed to policy responses designed to limit the ability of nursing home residents and their families to seek remedies through the courts for negligence and abuse committed by providers. They support nursing home litigation activity in the belief that state and federal quality assurance systems have been relatively ineffectual in forcing providers to maintain quality standards.

At the root of this policy issue are the views and perceptions of the American public. In negotiating settlements, plaintiffs and defendants make decisions about compensation for damages based upon their shared judgments of what juries *would* decide if cases were to go to trial. Most every person interviewed during this study, whether they were associated with the plaintiff side or the defendant side of the issue, agreed that the decisions of juries in nursing home negligence cases are virtually impossible to predict. One insurer said that it had conducted mock jury trials, testing the exact same case in the exact same manner, in front of multiple juries, with highly

diverse results. Because the decisions of juries are so hard to predict, regardless of the facts of the case, both plaintiff and defense counsel almost always prefer to settle cases without a jury trial.

When people are dying, and body systems are failing through natural causes, it is extremely difficult to determine what adverse outcomes are attributable to negligent care practices. The provider community claims that many lawsuits brought against them are for adverse outcomes that are beyond their ability to control or prevent. On the other hand, all will agree that providers need to be held legally accountable for maintaining reasonable quality of care standards for the residents they care for. The rise in nursing home litigation and the volatility in the nursing home liability insurance market are testament to the fact that, at the public policy level, these difficult questions have not been addressed, or resolved, as well as they could be. Considerably more research, legal analysis, and policy development, is needed to provide greater clarity and guidance to the American public on this difficult social issue. As the American public continues to age, and the demand for long-term care services continues to increase, this debate over what constitutes proper balances is likely to continue.

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GLOSSARY

Admitted Carriers are commercial insurers whose nursing home liability insurance products are regulated by state departments of insurance. These carriers enjoy some advantages over non-admitted carriers. They can participate in state guaranty funds, which help protect policyholders in the case of insurer insolvency. Also, they have a marketing advantage over non-admitted carriers because some brokers, facility providers and lenders value state oversight and participation in the guaranty fund.

The **Alternative Market** to nursing home liability insurance is composed of various forms of self-insurance, meaning the risk is borne by the participants and not an insurance company. The different forms of self-insurance include risk retention and risk purchasing groups (RPGs), captives, rent-a-captives, and sponsored captives (Joint Underwriting Associations).

Arbitration Agreements are contracts, the terms of which are determined by an arbitrator, entered into by opposing parties. An arbitrator is a person or panel of people who are not judges and may be: (1) agreed to by the parties; (2) required by a provision in a contract for settling disputes; or (3) provided for under statute. Arbitration is designed to be a fair and equitable means of dispute resolution agreed to by both parties to avoid a court trial and the associated expenses and time investment.

Capitalization means funding the reserves of an insurance or self-insurance program to pay claims**.**

A **Cell Captive** is a captive in which member providers share administrative expenses but not risk.

A **Captive** is a self-formed pool of providers who share risk among themselves, thus acting as their own insurance company. Members do their own underwriting, meaning they decide among themselves which providers to admit to the captive. Members will share liability risk with the providers they admit.

Claims Made Policies provide coverage for insured events that both occur and *for which a claim is made* during the term of the policy. Thus, if an incident occurs, but the policy is terminated before a claim is made, liability for the incident is not insured.

Claims Occurrence Policies provide coverage for all incidents and events that occur during the term of the policy, regardless of when a liability claim is made, or when a lawsuit is settled.

Collateral Damages are damages incurred by the plaintiff that are already covered by other sources of payment. ‘‘Collateral source offset’’ rules reduce awards by denying plaintiffs compensation for losses that are recouped from other sources,

such as health insurance. These rules aim to prevent plaintiffs from ‘‘double dipping’’ by recovering for losses for which the plaintiff has already been remunerated through other sources of payment.

Deductibles are initial amounts of claims incurred by the policyholder not covered by the insurance policy. Insurance coverage begins only for losses incurred above the deductible amount.

Economic Damages in civil litigation is compensation due the plaintiff for financial losses caused by the wrongful actions of another party (e.g., awards for the medical bills of a nursing home resident caused by an abusive employee).

Estimated Liability Costs are approximate calculations of expenses for damages to which a nursing home is exposed. Because estimates are derived from information provided by nursing homes and the cost of settlements of lawsuits is confidential information known only to the insurance carrier, plaintiff's attorney and defense attorney, these calculations are only estimates and are subject to change.

General Liability Claims/Losses are amounts a nursing home liability insurer is legally obligated to pay as damages to a plaintiff due to bodily injury or property damage.

A **Joint Underwriting Association** is a state-sponsored organization that creates insurance pools and functions as an insurer in markets without a significant number of licensed insurers. It has the power to sell insurance policies, collect premiums, and purchase reinsurance and it can usually guarantee a certain level of premium rates to its members. It can also levy surcharges on policyholders and, in some cases, on licensed insurers selling liability insurance, to create reserves to pay claims.

Joint and Several Liability in civil litigation is a situation in which the concurrent acts of two or more defendants bring harm to the plaintiff. Such acts need not occur simultaneously, but must contribute to the same event. In such a case, the damages may be collected from one or more of the defendants. If the court does not apportion blame in specific shares, the damages may be collected from any and all defendants. If a defendant does not have the financial wherewithal to pay, the others must make up the difference.

Non-admitted Carriers, also called **Surplus Line Carriers**, are commercial insurers whose nursing home liability insurance products are not regulated by state departments of insurance. These insurers enjoy some advantages over admitted carriers. They have greater flexibility in designing and pricing products. Because they are not subject to state regulation, they can also change coverage forms and application protocols more quickly. However, they must pay an “excess and surplus lines” tax that is not levied on admitted carriers. They cannot participate in state guaranty funds, which help protect policyholders in the case of insurer insolvency

Non-economic Damages in civil litigation is compensation due the plaintiff for intangible harms (e.g., pain and suffering).

Nursing Home Liability Insurance is indemnification of nursing home providers against damages for negligent care and abuse.

Nursing Home Residents' Rights Statutes are state and federal laws to protect each nursing home resident's civil, religious and human rights.

Offshore Captives are captives located outside the United States. The most popular host states for offshore captives include Bermuda, Guernsey and the Cayman Islands.

Premium is the charge paid by a policyholder for insurance coverage.

Professional Liability Claims/Losses are amounts a nursing home liability insurer is legally obligated to pay as damages and associated claims and defense expenses to a plaintiff due to a negligent act, error or omission in a nursing home provider's rendering or failure to render professional services.

Punitive damages in civil litigation means monetary compensation awarded by a judge or jury which exceeds the losses suffered by the injured party in order to punish the defendant.

Regulated Insurance Carriers are admitted carriers (see definition above).

Reinsurance is the practice of insurance carriers ceding risk to other firms, called reinsurance companies, in order to limit their liability exposure. Reinsurance companies essentially provide insurance to insurance companies. Instead of assessing the risk of individual policyholders, reinsurance companies assess risk on a broader scale, such as on the basis of a particular product-line (nursing home liability insurance) or a geographic region.

A **Rent-A-Captive** is a captive, usually formed by an insurance company, broker or captive manager, and rented out to users (in this case nursing home providers) who avoid the cost of funding their own captive. The user provides some form of collateral so that the rent-a-captive is not at risk from any underwriting loss suffered by the user.

Risk Management Programs are structured approaches to purposefully limit liability risk. They include systematic efforts to improve and maintain high standards for care quality, but can also include additional management techniques to minimize liability exposure, such as improving written documentation. They are often formalized within the management structure of nursing home providers in the form of Risk Management Committees, and/or a designated Director of Risk Management along with formal Risk Management plans that are implemented and monitored by senior management.

A **Risk Retention Group (RRG)** is an insurance company that is owned by its members. The members of an RRG come from the same industry. For instance, nursing home providers can form an RRG in order to obtain nursing home liability coverage.

A **Settlement** is an agreement reached between the legal counsel of the plaintiff and the defendant that terminates a civil litigation before a verdict is reached by the court.

Tort Reform generally means a movement intended to curb litigation and damages in the civil justice system. With respect to nursing home liability insurance, many states have enacted tort reform through legislation and it has changed the legal framework under which residents and/or family members can seek damages for negligent or abusive care practices. States also placed limits on the amount of damages that could be awarded to plaintiffs and/or their family members, particularly non-economic damages for pain and suffering.

Underwriting is the process by which an insurer assesses the risk of insuring a particular applicant for coverage. Risk retention groups also underwrite by assessing the risk of accepting a prospective member.

TABLES

TABLE 1: Average Loss Costs Per Occupied Bed As Estimated in 2002-2005 Aon Studies									
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
2002 Study	$830	$1,100	$1,290	$1,640	$1,970	$2,360			
2003 Study	$850	$1,210	$1,630	$1,820	$2,100	$2,340	$2,880		
2004 Study	$830	$1,300	$1,690	$1,730	$2,080	$1,980	$2,050	$2,290	
2005 Study	$820	$1,160	$1,660	$1,670	$2,070	$2,290	$2,230	$2,270	$2,310

TABLE 2: Comparison of Estimated Loss Costs, Claim Frequency, and Claim Severity in Aon and ISO Studies for 1998-2000				
	2005 Aon Study		**2002 ISO Study**	
Average Loss Cost Per Occupied Bed	1998 1999 2000	$1,660 $1,670 $2,070	1998 through 2000 average	$209
FREQUENCY				
Claims per 1000 beds	1998 1999 2000	8.2 10.1 11.1	1998 through 2000 average	1.5
SEVERITY				
Average cost per claim, including ALAE and indemnity expenses	1998 1999 2000	$203,000 $165,000 $187,000	1998 through 2000 average	$139,411

TABLE 3: Recent Tort Reform Initiatives in Selected States				
State Legislation	**Year**	**Restricting Access**	**Modifying Rules**	**Capping Awards**
Arkansas H.B. 1038	2003		X	X
Florida S.B. 1202	2001	X	X	X
Idaho H.B. 92	2003			X
Louisiana S.B. 748	2003	X		X
Mississippi H.B. 2	2002	X		
Mississippi H.B. 13	2004		X	X
Nevada A.B. 1	2002	X	X	X
Ohio H.B. 412	2002	X	X	
Ohio S.B. 281	2003			X
Oklahoma H.B. 2661	2004		X	X
Pennsylvania H.B. 1802	2002	X	X	
Pennsylvania S.B. 1089	2002		X	
Texas H.B. 4	2003			X
West Virginia H.B. 2122	2003			X

NURSING HOME LIABILITY INSURANCE MARKET

Reports Available

Recent Trends in the Nursing Home Liability Insurance Market (Main Report)
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab.pdf

Nursing Home Liability Insurance Market: A Case Study of California
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-CA.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-CA.pdf

Nursing Home Liability Insurance Market: A Case Study of Florida
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-FL.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-FL.pdf

Nursing Home Liability Insurance Market: A Case Study of Georgia
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-GA.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-GA.pdf

Nursing Home Liability Insurance Market: A Case Study of Ohio
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-OH.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-OH.pdf

Nursing Home Liability Insurance Market: A Case Study of Texas
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-TX.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-TX.pdf